Richards (H.)

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TWO NOTEWORTHY CASES OF TRAUMATIC RUPTURE OF THE MEMBRANA TYMPANI.

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The following cases, observed by the writer during the month of May, 1889, presented certain peculiarities which render them worthy of record in the published Report of the Otological Society. To avoid a waste of time on the part of those whose curiosity may prompt them to read this attempted description, as well as on the part of such members of the Society as may chance to hear it read at the annual meeting, I shall abstain from reference to the comparatively commonplace and trivial features of each case, endeavoring to limit my own attention and to invite that of others simply to their more uncommon and more salient features, and shall supplement the brief verbal description by pen and ink sketches as accurately representative of the lesions observed as it is within my power to make them.

Case I. was seen at the Vanderbilt Clinic on May 7th. It was that of a woman about thirty years old, who, two days before, had received a box on the left ear. The symptoms were those of vertigo, tinnitus, and marked deafness. There had been no bleeding or other discharge from the ear. The membrana tympani showed some evidence of pre-existing tympanic catarrh, in that it was somewhat depressed and moderately atrophic. Save for the pronounced injection of the manubrial vessels and a narrow red line along either border of the gaping opening, it was not congested; the extensively exposed inner wall of the tympanum was likewise pallid and secreting only sufficient mucus to give its surface a glistening appearance.

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Figure 1 shows the shape, extent, and location of the rupture. Figure 3 shows the drum-membrane nearly healed, and as it appeared sixteen days later; by which time the patient's hearing had greatly improved and (if I recollect aright) the tinnitus and vertigo had quite disappeared. The patient, on this, her last visit to the clinic, certainly considered herself quite recovered. Figure 2 shows an intermediate stage of the healing process. All three drawings are copied from sketches made on the spot and entered in the history book of the aural department. The centrifugal progress of cicatrization was throughout a marked feature of the case. Treatment consisted in successful efforts to induce the patient to leave her ear alone. For a few days I advised the wearing of a small loose cotton obturator in the auditory meatus; but this I subsequently discontinued because the patient seemed to have crowded it too far and too tightly into the canal.

Fig. 1. Fig. 2.

Fig. 3. Fig. 4.

Case II. was that of a woman twenty-three years old, who consulted me at the New York Eye and Ear Infirmary on the 24th of May. The pathological appearances were singularly like those observed in Case I., yet not identical, and the history of trauma was less clear. The location of the perforation and its shape were precisely those I had seen in the other case; its size was if anything a trifle larger. As in Case I., there was no discharge; and the patient said there had never been any, nor had there been any bleed-

ing from the ear. In this second case there was no congestion whatsoever, either of the membrane or of the tympanic wall. The membrane was greatly retracted and the other ear showed distinct but, as I recall the case, not especially marked evidence of catarrhal change. Figure 4, copied from a pencil sketch made on a prescription blank at the time of the first visit, shows the appearances seen in the ear with tolerable accuracy.

This patient, unlike the one seen at the Vanderbilt Clinic, had complained of aural symptoms for several weeks prior to my seeing her. These symptoms had been those simply of occasional slight pain in the ear. For their relief on May 21st, three days before I saw her, she had consulted a physician who had examined the ear by a head-mirror, had made the diagnosis of catarrh, and, during the examination, had introduced, so the patient said, a probe armed with cotton. This procedure had made her so dizzy that she was obliged to lie down immediately. Within two hours after the examination she discovered that she was very deaf in that ear. For manifest reasons I reserved my diagnosis and gave a guarded prognosis. The treatment advised was absolutely negative; even the wearing of cotton in the ear being forbidden.

Four days later, on May 28th, and seven days later, on May 31st, an examination showed that no change whatever had occurred. Tentatively, on May 31st, I stimulated the borders of the opening with a nitrate of silver solution, being careful to avoid an entrance of the solution within the tympanic cavity. I also insufflated an exceedingly minute quantity of powdered boric acid. A few days later the patient came to see me at the Vanderbilt Clinic, saying that her ear felt better, and that, if possible, she wished to move into the country. On examining the ear, I found, to my surprise, that the great wedge-shaped gap in the drum-membrane had healed across, save for a still persisting very small and circular

opening situated about midway between the malleolus-tip and the lower border of the membrane. I greatly regretted losing another opportunity of examining the now rapidly and suddenly healing membrane, but could not conscientiously tell the patient that she had better defer her moving to the country on account of her ear.

Cicatrization in the first recorded of these two cases occurred spontaneously, without doubt; I have no proof that it did not do so in the other also. The first case was from the start plainly due to trauma; the chief reason for believing the second to be due to the same cause — although not the sole reason — was the rapid closure of the opening.